Physician or Practitioner Certification
For Family or Medical Leave

Dear Physician or Practitioner:
To assist in establishing leave entitlements under Wisconsin's Family and Medical Leave Law (Section 103.10, Wisconsin Statutes) please answer the questions below and return this certification to Employer.

Employer Information

Employer Name			
Street Address	City	State	Zip Code

Employee/Patient Name

Employee Name	Patient Name (if not employee)

Information Requested

Does _____ have a serious health condition? Yes No
(Patient Name)

Note: Wisconsin's Family and Medical Leave Law (Section 103.10 Wisconsin Statutes) defines a **serious health condition** as a disabling physical or mental illness, injury, impairment or condition involving either inpatient care in a hospital, or outpatient care that requires continuing treatment or supervision by a health care provider.

What date did the condition begin?

What is the probable duration of the condition:

Specify medical facts regarding the serious health condition:

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entitles covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information" as defined by GINA, includes an individual's family medical history, the results of an individuals' or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

_____

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_____

Please indicate the extent to which the employee is unable to perform his or her employment duties.

_____

_____

Physician/Practitioner Information

Physician/Practitioner Name (Please Print)	
Physician's Signature	Date Signed

Please Return To Clark County-Office of Personnel
Fax: 715-743-5159